Serious Case Review – Baby E
Agency progress against action plan recommendations – June 2017

The Serious Case Review for Baby was completed in 2013. However, the Buckinghamshire Safeguarding Children Board (BSCB) has been unable to publish the report until now due to ongoing criminal enquiries.

Since the completion of the report, the BSCB has been monitoring progress against the recommendations. The following statements, from those agencies directly involved in the review, give a brief summary of how the review recommendations have been implemented.

1 Buckinghamshire Safeguarding Children Board

The review recommended that there should be a local framework for assessment to provide a sound basis for multi-agency assessment. Since the review, the BSCB has undertaken significant work around local thresholds, including significant training and awareness raising and revising our thresholds document to take on board feedback from a multi-agency consultation. There is now strong evidence of improved knowledge of thresholds across the partnership, which is informing effective assessment across all levels of need. The BSCB has also strengthened multi-agency policies and procedures relating to assessment, and the Local Authority has produced a Local Protocol for Assessment which will further inform multi-agency practice.

The review identified some learning around the way joint investigations are carried out between Social Care and Thames Valley Police. Since then there has been significant work in this area, including the production of good practice guidance which has helped to clarify the roles and responsibilities of those involved.

The review identified the need develop a culture which includes working with both parents. Since this review the Board has undertaken further activity, including both serious case reviews and audits, which continue to highlight the need to ensure fathers are included and that information on fathers is more robustly recorded in case files. We have undertaken work in partnership to explore some of the challenges in this respect and continue to share learning with practitioners to improve practice. This is an area we will continue to monitor through routine performance and auditing activity.

The review identified the need to work with the Clinical Commissioning Groups (CCGs) to bring GPs into the centre of child safeguarding. Since the review there has been significant work within the CCGs, some of which is described in the CCG statement below, to facilitate effective multi-agency information sharing. However, effective sharing of information across all agencies and the involvement of all relevant professionals in multi-agency meetings is an area where there is always room for further improvement. The BSCB recognises significant and ongoing work around these areas across a number of partners and continues to offer both support and challenge to drive improved practice.

The review recommended that training courses needed to encourage a culture of critical thinking around domestic abuse to facilitate the identification of risk factors. The BSCB training course on domestic abuse has been updated, and along with all other BSCB courses is clear around the need to avoid making assumptions, and to use robust assessment to understand risk factors and need. For 2017/18 the BSCB has made Domestic Abuse a core priority area. As a result of this we will be undertaking further work over the coming months to look at the effectiveness of our whole system approach to Domestic Abuse.

2 Buckinghamshire Healthcare NHS Trust

Buckingham Healthcare NHS Trust (BHT) has contributed fully to this complex case review and the Trust entirely endorses its findings and recommendations. We have continued to work in co-operation with partner agencies to implement the actions required in order to ensure the permanent and sustained improvement of services to children and their families.

The Trust has already responded to the recommendations made, specifically addressing the issues of communication between community practitioners and GPs. In addition shared assessments during pregnancy and enhanced communications between midwifery and health vising services are now in place.

We are committed to continuously improving the care we provide to children and their families and being responsive to their needs.

We will continue to regularly and rigorously monitor and review all our actions to ensure that the lessons learned are embedded within the relevant services. BHT is a committed member of the multi-agency partnership for safeguarding children and will also support the actions and learning from this review across all agencies in Buckinghamshire.

3 Buckinghamshire County Council – Children's Social Care

Since the events of this review, Children's Social Care has had external scrutiny and support through an Improvement Board to drive forward services for children in Buckinghamshire. The recent Ofsted monitoring visits to Children's Social Care confirm that we are making progress, and that social work practice is strengthening. Children's Social Care will continue to build and sustain this improvement to further safeguard children and families.

There has been a review of procedures and guidance and these have been updated and strengthened in several areas, including Children in Need guidance which has been consolidated and updated; and multi-agency assessment guidance which is now included in Core Training. Organisational practice change which is developing systemic practice will continue to promote multi-agency working. A working group has carried out a full review on the use of written agreements with families; these are now referred to as Contracts of Expectations. Practice guidance has been developed and circulated to staff.

A new Joint Investigation Protocol has been developed and approved for use in conjunction with Thames Valley Police. This will ensure that both agencies are clear about their roles and responsibilities.

It is important that social workers have a thorough understanding of domestic abuse and the dynamics of this in families to assist them in making better judgements about children. Practice has been reviewed and changed so that social workers, particularly newly qualified social workers, receive more effective guidance in this area.

Stronger measures have been taken to ensure that understanding of babies' vulnerability is a key element of standard child protection training, along with a more robust procedure for escalating cases where there is no definite evidence of danger to a baby.

4 Buckinghamshire County Council – Adult Social Care

Procedures for initial stages of work carried out by the Out Of Hours (OOH) team have been reviewed and updated, and an information sharing checklist/referral tool has been developed and shared with staff. Skills audits have identified gaps and training needs for recording of information by the OOH team on electronic records, and relevant training has been carried out with regular refresher training as appropriate.

Procedures and guidance to ensure effective decision-making in the assessment phase has been strengthened through identification of training needs alongside mandatory training undertaken by all staff. There is now a risk assessment in place for staff to use in relation to safeguarding and mental health referrals.

Changes to procedures have been made to ensure that other children or adults within a family who may be at risk are identified promptly and any risks acted upon. Guidance has been updated and circulated to staff to support this. Clear time standards are also in place in line with the safeguarding procedures for children's and adults referrals. Staff are clear that risks must be assessed immediately and response/decision within four hours following alert.

A review of the use of written agreements has been superseded by having advocates present during Public Law Outline (PLO) agreements.

A checklist tool has been developed alongside accompanying training to ensure more effective processes for cascading actions and decisions with relevant agencies, so that all agreed actions take place as planned.

A dedicated Business Support Officer has been recruited to strengthen and develop the handover process between day and OOH services. Ongoing regular checks on the quality of information passed between the OOH team and the day team are carried out by managers.

5 Thames Valley Police

The specific recommendations for Thames Valley Police in relation to this case were centred on the way in which the Force undertakes domestic abuse risk assessment work. Actions have been taken to ensure that all officers understand the need to ensure that any domestic abuse assessment takes full account of the history of all household members, both in relation to domestic abuse and child protection.

Officers and staff have been reminded of the need to carry out a domestic abuse risk assessment at every domestic incident, irrespective of how recently one has previously been completed. This is also now included in ongoing training.
Work has taken place to ensure that all staff are reminded of the need to ensure that full details of any person taking over care of a child or vulnerable person are recorded, and the necessary police checks are conducted on these people.

These measures will strengthen the Force's ability to share information relating to risk assessment work carried out in domestic abuse cases, and will ensure that risks are identified and acted upon as quickly as possible, and that victims of domestic abuse continue to be safeguarded and supported.

6 Buckinghamshire Clinical Commissioning Groups

Since the serious case review for baby E was completed the clinical commissioning groups have worked with General Practitioners in Buckinghamshire to encourage better use of liaison meetings to improve information sharing between practitioners. A recent multi-disciplinary audit has shown improved liaison between GP's, Health Visitors and Community Midwives. There is a robust multi-agency escalation policy in place which enables concerns to be dealt with a timely manner. The CCGs provide regular update training to GPs including information and learning from local serious case reviews and national guidance. These sessions are well attended and well received.